DR WONG WAI PING & ANOR

v.

WOON LIN SING & ORS

HIGH COURT MALAYA, KUALA LUMPUR
LOW HOP BING J
[CIVIL APPEAL NO: 12-223-92 & 12-225-92]
28 JULY 1998

TORT: *Negligence - Medical negligence - Death of patient upon delivery of baby - Whether doctor liable - Doctor's duty of care to patient - Whether breached - Departure from normal course of treatment - Whether justified - Damage suffered by patient - Whether flowed from said departure - Whether proved otherwise*

TORT: *Vicarious liability - Hospital - Whether liable for conduct of doctor*

EVIDENCE: *Presumption - Witnesses not produced but named in evidence - Whether unfavourable to defendants - Evidence Act 1950, s. 114(g)*

In this case, the Sessions Court had found the 1st appellant wholly liable in professional medical negligence for the death of one patient, Yong Siew Yin, consequent upon her delivering a baby. The 2nd appellant was held to be vicariously liable for the conduct of the 1st appellant. Hence this appeal by the appellants against the decision of the Sessions Judge on the issue of liability.

The 1st appellant submitted that the respondents had to show: (1) that there was a normal course of medical treatment applicable in this case and that the 1st appellant had not adopted this course; and (2) that the course the 1st appellant took was one which no professional doctor of ordinary skill in his position would have taken. The 2nd appellant, however, denied that it was vicariously liable for the conduct of the 1st appellant.

Held:

[1] A doctor owes a duty to his patient to observe precautions which are normal in the course of treatment given. Where a patient suffers damage after there has been a departure from the orthodox course of treatment, the court has to inquire whether the doctor has taken all proper facts into account in order to determine whether that departure is justified. If it is not, that departure is a breach of the duty owed to the patient.

[2] The departure from the general practice by the 1st and 2nd appellants' staff was not justified and accordingly there had been a breach of the duty of care owed to the patient. Moreover, the appellants had failed to establish that the damage suffered by the patient had not flowed from their breach of the duty of care. The appellants had therefore been negligent.

[3] The failure of the appellants to call persons named in evidence as witnesses called for the application of s. 114(g) of the Evidence Act 1950 wherein the court may presume the existence of any fact which it thinks likely to have happened, and that that evidence which could be and is not produced, would if produced, be unfavourable to the person who withholds it.

[4] The facts clearly showed that the 1st appellant was a servant or agent of the 2nd appellant. No notice was brought to the attention of the respondents about the internal arrangement between the 1st and 2nd appellants, which was neither legally binding on the respondents nor exempted the 1st appellant from liability for negligence.

[Appeal dismissed.]

Case(s) referred to:
Clark v. Maclennan And Anor [1983] 1 All ER 416 ***(refd)***
Olley v. Marlborough Court Ltd [1949] 1 All ER 127 ***(refd)***

Legislation referred to:
Evidence Act 1950, ss. 106, 114(g)

Other source(s) referred to:
Encyclopaedia Britannica, vol 13
Fundamentals of Obstetrics and Gynaecology, vol 1, pp 119, 369, 404
Manual of Obstetrics, Holland & Brews, p 645
Obstetrics and the New Born, pp 113, 371
Obstetrics Illustrated, p 476
Obstetrics by Ten Teachers, pp 184, 281
Traumatic Medicine and Surgery for Attorney, vol 5, pp 104 para (2), 129

For the 1st appellant - RR Sethu (Andrew Khoo with him); M/s Khoo & Sidhu
For the 2nd appellant - Cecil Abraham (Robert Lazar & Chacko Vadaketh with him); M/s Shearn Delamore & Co
For the respondents - Dato' RK Nathan (Victoria Martin with him); M/s RK Nathan & Co

Reported by Usha Thiagarajah

JUDGMENT

Low Hop Bing J:

Appeal

On 20 June 1992, the Sessions Court Judge in Kuala Lumpur found the 2nd defendant Dr Wong Wai Ping herein wholly liable in professional medical negligence for the death of the patient Yong Siew Yin consequent upon her delivering a baby. The 1st defendant, Hospital Pantai Sdn Bhd was held to be vicariously liable for the conduct of the 2nd defendant. For ease of reference, the respondent in this appeal shall be referred to as the plaintiff and the appellants *viz* Hospital Pantai Sdn Bhd and Dr. Wong Wai Ping, as the 1st defendant and the 2nd defendant respectively. Both the defendants, being dissatisfied with the said decision, appeal to this court in respect of the issue of liability only.

Complexity Of The Case

The factual matrix of this case based on medical negligence is somewhat complex, and the trial sessions court judge did experience enormous difficulties in attempting to put the facts and circumstances of the case as comprehensibly as possible. The complexity of this appeal, by way of rehearing, is reflected in 3 substantial volumes of the appeal record, consisting of a total of some 1300 pages of notes of evidence, documentary exhibits and grounds of decision. In addition, there is a need to peruse an equal number of pages found in numerous formidable bundles of authorities, including medical literature made up of words of learned length and thundering sound. In the circumstances, the writing of this judgment is undoubtedly an increasingly assiduous task which has to be performed with meticulous care and attention, so that the parties herein would have the opportunity to perceive and understand the merits, and also the whys and wherefores of their respective cases.

Facts

Plaintiff's Case

The plaintiff is the husband of the deceased. On 24 May 1987, between 8.00 and 9.00 a.m., the plaintiff's wife complained of wetting and so the plaintiff called the Pantai Medical Centre (PMC). The plaintiff was told to bring his wife to PMC for checking and observation. The plaintiff took his wife there at 2.15 p.m. when she was admitted for observation. One nursing sister Mah informed the 2nd defendant of the patient's request to see the 2nd defendant. The 2nd defendant saw the patient at 10.00 p.m. the same evening.

Plaintiff visited his wife the next day on 25 May 1987 at 8.45 a.m. and was told by his wife that she had been put on drips since 7.45 a.m. on 25 May 1987. At about 11.00 a.m., his wife complained to him that the 2nd defendant did not use a special machine i.e. a cardio-meter to monitor her heart beat and that of their baby. At 11.30 a.m., she complained of slight pulling pain at the lower part of the stomach. After the plaintiff had come back from lunch, his wife told him that the 2nd defendant had informed her that the baby would be delivered at 5.00 p.m., or else at 9.00 p.m. Meanwhile, her contractions were becoming more regular. At 3.25 p.m., she was transferred to the labour room, accompanied by her husband. To ease the pain due to contractions, one nursing sister Ng gave her an injection at 4.30 p.m. The pain relief lasted for 20 minutes, after which the patient was given laughing gas i.e. nitrogen oxide to inhale. Later, the plaintiff went for dinner. Upon his return at about 5.30 p.m., he did not see the 2nd defendant in attendance. At 6.10 p.m., the plaintiff's sister-in-law told him that the 2nd defendant expected to deliver the baby at 9.00 p.m. Meanwhile, the 2nd defendant went home. At 6.40 p.m., on complaining of unbearable pain, the patient was given a second pain relieving injection. The patient was told not to push the baby as it was not due at that time. Both the baby's and the mother's heart beat respectively were not monitored, neither were the uterus contractions. At 6.50 p.m. the patient was given a second tank of laughing gas and this time she administered it herself. Meanwhile, two nursing sisters were discussing the amount of solution to be added to the drips, in the absence of further instructions from the 2nd defendant. At about 7.30 p.m., the patient was bleeding and fully stained with blood, as a result of which, the plaintiff had to change the tissue papers for her. Although three layers of tissue papers were laid there, his wife's bottom was fully stained with blood. The plaintiff informed one attendant named Tina about the staining of blood at about 8.00 p.m., but Tina did nothing. The 2nd defendant was not informed. The plaintiff had to put his wife back to bed and changed her sanitary pads many times.

All this while, the plaintiff asked for the 2nd defendant and was told that the 2nd defendant was coming. The baby was delivered by the 2nd defendant at 9.05 p.m. The plaintiff was told that both his wife and their baby girl were normal. The plaintiff then went to the labour ward to see his wife at 9.20 p.m. He saw a nursing sister on the phone, shouting to another sister standing in front of the labour ward, as to whether it was two pints of blood that the 2nd defendant wanted. The nursing sisters were apparently in a state of commotion. At about 9.30 p.m., the 2nd defendant came out and told the plaintiff that certain complications had arisen. The 2nd defendant requested the plaintiff to sign a form for an emergency operation, which the plaintiff did as he had no choice. The patient was taken to the operating theatre (OT). The plaintiff followed and peeped through the swing door. He saw that his

wife was pale and motionless. Nothing was attached to any part of her body. There was no oxygen tank inside the OT.

Until 10.45 p.m., the 2nd defendant made no mention of amniotic fluid embolism (A.F.E.), but told the plaintiff that the plaintiff's wife had suffered a shock and her heart had stopped beating for a while. The 2nd defendant managed to revive the patient's heart-beat. The patient was still bleeding and had brain damage.

At about 11.45 p.m. the patient was transferred from the OT to the Intensive Care Unit (ICU) where an artificial respirator was attached to her on 26.5.1987, at about 2.45 a.m.. The plaintiff met one Dr. Damu who was assisting in the recovery of the patient. At about 3.00 a.m. the plaintiff met the 2nd defendant who told him that Dr. Damu was not pleased that the plaintiff's wife was not reacting to certain drugs. At about 7.30, a.m. the plaintiff met Dr. Damu at the ICU but the 2nd defendant was not there. Dr. Damu told the plaintiff that there was no change in the patient's condition. The plaintiff's wife was still bleeding, but blood transfusion had stopped as the drips were pulled out.

At about 12.00 noon, one Dr. Ng, a cardiologist from PMC, took the plaintiff to a special private room, where Dr. Ng told the plaintiff that the plaintiff's wife was medically dead, and advised the plaintiff to either take the plaintiff's wife home or keep her indefinitely on a respirator. The plaintiff could not accept that his wife was dead and so requested a neurosurgeon to examine his wife. One Dr. Mohandass, who was then called in, confirmed that the plaintiff's wife was brain-dead. Refusing to give up hope, the plaintiff then requested one Dr. Nadarajah to examine his wife and also insisted on blood transfusion to continue. The plaintiff was told that he had to arrange for blood to be donated before PMC could give any blood transfusion.

At about 5.00 p.m., Dr. Nadarajah who examined the plaintiff's wife told the plaintiff that she had suffered shock and had lost a lot of blood in the labour ward. Since her brain was devoid of oxygen (from lack of blood) for more than 3 minutes, the brain had suffered permanent damage, in which case, the various parts of her body could not be controlled or regulated and that the last organ to fail was the heart.

At 8.00 p.m. when a nurse administered a drug in the form of an injection, the plaintiff asked the nurse what it was but the said nurse referred him to the 2nd defendant. Immediately after the injection was administered, the heart beat on the screen flattened to a horizontal line. The 2nd defendant pronounced the patient dead at 8.50 p.m.

The plaintiff then lodged a police report and the police took the body for post-mortem. The post-mortem report revealed, *inter alia*, that the plaintiff's wife

had a wall-to-wall tear in the vagina. The 2nd defendant never told the plaintiff that the baby was delivered with the use of forceps.

In the course of the hearing in the Sessions Court, the plaintiff was allowed to amend the particulars of negligence and the following new sub-paragraphs were included:

(j) that as a result of such laceration, amniotic fluid was able to enter the blood stream.

(k) Using forceps which were unsuitable in the said situation and thereby causing the laceration and allowing for amniotic fluid to enter the blood stream.

Defendant's Case

The 2nd defendant first saw the patient on 13 February 1987 and had seen her a total of eight times before delivery. He maintained the deceased was not in the high risk category. High risk cases are classified under physical social factors and medical factors. High risk cases classified under physical social factors are:

(1) a woman above 35 years old;

(2) a woman (above 35 years old) having a first child;

(3) a woman on a 4th pregnancy;

(4) a woman, in this part of the world, at the height of 4' 10" or below; and

(5) a woman from poor social economic group.

High risk cases classified under medical factors are sub-divided into two types, *viz*:

(1) Obstetric factors relating to delivery e.g:

(a) previous caesarean section;

(b) previous neo-natal death;

(c) having a baby dying in a previous delivery;

(d) still birth i.e. baby dying before delivery;

(e) previous difficult labour; and

(2) Associated mental conditions e.g.

(a) diabetes mellitus in pregnancy;

(b) hypertension, toxaemia pregnancy –

a special form of hypertension; and

(c) heart condition in pregnancy.

The 2nd defendant examined the patient on 23 May 1987 morning (Saturday) and found her very well. Her BP was 110/80. She was at term exactly on the expected date of delivery, calculating from her last period. Upon examining the patient, the 2nd defendant found her uterus enlarged to term size, the head was present and was engaged i.e. the greater part of the foetus head had gone below the pelvic brim.

In the patient's earlier visits, the 2nd defendant explained to her the labour ward procedure, essentially about the signs of early labour, when to admit herself to hospital and what to expect when she got admitted. The patient was admitted on 24 May 1987 to the labour ward. Nursing sister Mah gave the 2nd defendant the patient's clinical condition. After examination, nursing sister Mah told the 2nd defendant that the patient was not in labour. As the 2nd defendant was conversant with the patient's case and since the patient was expected to deliver any time, the 2nd defendant ordered an enema and requested her to be observed and monitored. The 2nd defendant was at home then and called the hospital to enquire of the patient's condition at about 6.00 p.m.. The 2nd defendant was informed that the patient was well and had not started labour or contractions.

The 2nd defendant saw the patient in the labour ward at about 9.00 p.m. After doing a full physical obstetric examination, he found the patient's uterus was not contracting. The head was engaged while the cervix was long and tubular. The lower – most pole of the head had descended to the level of the mid cavity i.e. at station zero. The diagnosis then was that of a 32 year-old primigravida at the onset of labour. Because the cervix was long and tubular, the 2nd defendant concluded that the patient was unlikely to deliver that night. The 2nd defendant discussed with the patient the need to open the cervix by way of pitocin drip. The same night, the patient was given buccal pitocin to help in the contraction process.

On 25 May 1987 the next morning he saw the patient again at 8.50 a.m. By now she had had a drip with pitocin. There was tightening of the uterus in a non-pattern manner. The 2nd defendant felt the patient had not gone into labour. By medical definition, established labour consists of rythmic uterine contractions of at least 1 contraction in every five minutes lasting 30 seconds and it must be a recurring pattern over a period of time. Based on this, the

2nd defendant felt the patient was not in labour. The 2nd defendant instructed the nurses to continue the drip and to increase the strength of pitocin when necessary.

A schedule was set up by which the nurses had to increase the amount of pitocin until strong uterine contractions appeared. The nurses are allowed to cut down the drip rate when they feel the contractions are too strong or take off the pitocin drip if they feel the uterus is over-reacting. The labour ward has a set of observations that is mandatory for the nurses to follow.

The 2nd defendant examined the patient at noon (four hours later) and found that the uterus was beginning to contract more frequently than 1 in every five minutes, and the 2nd defendant felt the patient could have reached labour at 11.00 a.m. when the head was engaged and the back of the baby was facing lateral medial i.e. occipital lateral. He ordered that the patient be given sedation and analgesic if necessary.

On seeing the patient at 5.00 p.m., the 2nd defendant found the patient had contractions 1 in every 3 minutes with moderate intensity and the position was still in position, occipital lateral. Fluid from the vagina was tinged with blood.

At 6.00 p.m. the 2nd defendant examined the labour ward records which showed that the cervix had dilated to about 2 fingers i.e. about 4-5 cm. Based on this, the 2nd defendant felt the patient would deliver around 9.00 p.m. The cervix tends to dilate in a certain pattern when the patient goes into established labour and this pattern has to be documented. Up to a certain point it is possible to predict the time of delivery, as a graphic partogram would show the time of delivery and if there is a delay by 2-4 hours, then it is necessary to find out the cause of delay. The 2nd defendant then went home.

At about 8.30 p.m. the 2nd defendant received a call from the hospital that the patient was beginning the second stage of labour in which the cervix had fully dilated i.e. the birth canal has now formed into a fully cylindrically fleshy canal down which the baby can be delivered without obstruction. The 2nd defendant told the nurse to get the patient to push the baby out i.e. by the addition of her own body power to the uterine contractions. About 5-10 minutes later, the 2nd defendant received another call that the baby's heart beat had dropped to less than 120 per minute, suggesting that the baby was in distress. The 2nd defendant left his house and reached PMC within 5 to 10 minutes, went into the labour room and found the patient in pain.

The 2nd defendant listened to the baby's heart and confirmed it was in distress. The cervix was fully dilated and the head was presenting. The 2nd defendant could see part of the baby's hair as soon as he opened up the valva. The

station or the lower most pole of the head was at plus 1 and below. There was no moulding i.e. overlapping of the bones. The head was in occipital-posterior position, meaning the head was facing backwards.

Because of the foetal distress, the 2nd defendant felt the need to deliver the baby as soon as possible. Since the greater part of the head had reached the lower half of the birth canal and as the lower-most pole of the head was just about 1-2 cm from the valva, the 2nd defendant decided on forceps delivery.

The defendant had ruled out caesarean section because:

(1) the baby was on the point of delivery and it would take 15-20 minutes to set up caesarean section, thus depriving the baby of oxygen;

(2) the head was so low down that one has to dislodge the baby upwards into the upper part of the birth canal, which is dangerous as one has to catch the baby's head and push it up. The cord can collapse and cause foetal death; and

(3) by now, the muscles of the uterus had wrapped itself very tightly round the baby and it is difficult to push; if excessive pressure is used, there can be uterine tear.

From satisfactory contraction to full cervix, the time taken was 9½ hours.

One of the methods considered for occipital posterior (OP) position was manual rotation followed by forceps delivery. This could have been considered seriously if the lower-most pole of the baby's head was at the pelvic canal i.e. narrowest part of the bony birth canal.

To do a manual rotation, the head has to be pushed up beyond the level of the ischial spine. This is physically disimpacting the head from the lower part of the birth canal.

The uterine muscles have moulded themselves round the baby's body and the baby's head had moulded itself to the structure of the canal. The pelvis was anthropoid pelvis and did not allow for rotation.

The other method used for rotation is the Kielland's forceps. This was not considered because it was a difficult forceps to use and whoever uses it would like to use it under general anaesthetic. Further one never uses it in the anthropoid pelvis. The malstrom vacuum suction was not considered as it would take time and further it could cause tear in the scalp.

Therefore the 2nd defendant chose the Naville-Barnes forceps, a medium sized forceps with 2 curves i.e. a curve for the foetus and one for the pelvic curve. This cannot be rotated.

a After ascertaining that the lower-most pole of the foetal head was in the lower pelvis, the 2nd defendant used the forceps without difficulty. Because it was an OP position, the forceps blade had to be placed slightly higher than in normal forceps for the occipital anterior (OA) position. The 2nd defendant then did a very wide right-medio lateral episiotomy because he anticipated that in *b* an OP position, the presenting diameter, when one delivers the baby, is larger than the normal OA position.

After the baby was delivered, the 2nd defendant began suturing the episiotomy. The 2nd defendant found 2 small lacerations on the left of the vagina, 1 and 1 1/2 cm which were parallel and near each other, and about 2-3 cm deep to *c* the valva.

The 2nd defendant put a few sutures into these 2 lacerations which stopped the bleeding. He then started suturing the episiotomy, starting from the top and proceeding downwards. After completing the vaginal part, he put a small *d* piece of gauze. As he was about to finish suturing the skin, he noticed a bit more blood than usual, staining the gauze. As he pulled the gauze away, there was a gush of blood. Up to that point, the patient may have lost 200-250 mls of blood. The 2nd defendant asked the nurses to help retract the vagina for him to have a better vision. He then noticed some blood coming out of the vaginal lacerations. Since the nurses told him the uterus was well contracted, *e* he concluded that the 2 lacerations could be the further cause of the bleeding.

The 2nd defendant put in several figure-of-8 stitches to stop the bleeding from the 2 lacerations, but it continued to ooze. After about 5 minutes, he wanted to examine the patient under anaesthesia, to allow him to see for tears, *f* lacerations in the cervix, the wall of the vagina; in fact the whole of the vagina. It would also allow the 2nd defendant to put his finger into the uterus through the cervix to look for conditions that could produce bleeding from the uterus e.g. like a uterine tear or whether he had left pieces of placenta inside. It also allowed him to tell whether there was bleeding outside the uterus *g* and vagina, as doctors always fear hidden bleeding in the lower part of the pelvis. It also allowed the 2nd defendant to look at the lacerations again properly lest he had missed out a bleeder. He also ordered blood to be cross-matched as one might need it.

While the 2nd defendant was obtaining some blood from a vein on the *h* patient's left hand (to see if there was any coagulation problem), the patient began to show excessive bleeding and she collapsed. She also had cyanosis of her fingers, meaning there was an increase of carbon dioxide in her blood, more than the normal.

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The 2nd defendant then connected another drip (now there were 2) and ordered Hartmann's solution to be infused quickly. He applied oxygen masks 4 times on her to help increase the oxygen. The patient was then taken to the operating theatre (OT). The 2nd defendant was worried as it suggested sinister pathology. By now, the 2nd defendant estimated the patient would have lost about 400 mls of blood. The patient suddenly collapsed. The 2nd defendant considered the following as possible causes:

(a) bleeding into the paritoneal cavity;

(b) a partial inversion of the uterus;

(c) a tear of the cervix, of the wall of the vagina;

(d) a large collection of blood on the back of the uterus;

(e) amniotic fluid embolism;

(f) cerebral infarction; and

(g) myocardial infarction.

The 2nd defendant proceeded to the OT as he wanted the examination under anaesthesia to continue. More importantly, at that moment he thought the patient had amniotic fluid embolism (AFE), the management of which was to provide cardio-pulmonary resuscitation. Just then Dr Manavalan entered the labour ward area. The 2nd defendant, Dr Manavalan and a few nurses pushed the patient to the OT and after this Dr Manavalan took over the management of the patient. The 2nd defendant then went out of the labour ward area at about 9.50 - 10.00 p.m., when he met the plaintiff and told the plaintiff of the possibility of further surgery. The plaintiff signed the consent form. Before the 2nd defendant could explain to the plaintiff further, the plaintiff urged him to assist the patient.

When the 2nd defendant entered the OT, the patient was already under anaesthesia and ready to be examined. All this time, the nurses were running in and out of the OT and labour ward. The nurse assisting the 2nd defendant that day was assistant nurse Sarojini. The 2nd defendant first examined the uterus to exclude inversion or uterine tear or to ascertain whether any placenta was left in. The 2nd defendant then pulled down the cervix and saw some small tears which gave not much bleeding. However, the earlier 2 lacerations were there. The 2nd defendant then cut open the earlier sutures and tried to look for a bleeding vessel. He then put several haemostatic sutures to stop the bleeding which stopped temporarily. Because the episiotomy was oozing, he reopened the episiotomy and looked for bleeders and this time put thick haemostatic sutures. He then noticed the earlier lacerations continuing to bleed. All this took 10-15 minutes.

By now, Dr Manavalan had stopped the 2nd Defendant as the patient's blood pressure (BP) was unrecordable and Dr Manavalan concentrated on cardio-pulmonary procedures. The 2nd defendant then put metal clamps on the cervix and the vaginal lacerations and packed the vagina while waiting for Dr Manavalan to review the patient. When the patient's BP rose, the 2nd defendant and an OT nursing sister started exploration and suturing again started with the cervix. The 2nd defendant had another look at the sutured episiotomy which was still oozing. He then removed the pack, the clamp and all the haemostatic sutures. This time, he saw the wound was swollen and friable i.e. easily traumatised. He opened the 2 lacerations and looked for bleeding vessels. He then started resuturing and Dr Manavalan again told him that the patient's BP was unrecordable. He abandoned further surgery as the wound was incompletely sutured and put in a large vaginal pad, hoping it would provide the needed pressure to slow or stop the bleeding.

Dr Manavalan and the 2nd defendant started cardiac massage. Dr Manavalan also gave the patient cardiotropic drugs. Later anaesthetist, Dr Damodaran, took over the cardiac massage. They succeeded in reviving the heart beat.

They then decided that it was pointless to suture her again and they sent her to the intensive care unit (ICU) on the 4th floor of PMC. There was still bleeding from the vagina. The 2nd defendant then removed the earlier pack with the help of a nurse and inserted a fresh pack. He then left to inform the plaintiff and told him the patient's heart beat had stopped and that the patient had gone into cardiac arrest. They were unable to revive the patient and were now sending her to the ICU. The patient was attached to various instruments, including a cardio-respiratory machine. The 2nd defendant noticed that the patient was still bleeding right through the vaginal pad. He then removed it and put in another pad and put in a few more sutures (in the ICU).

The 2nd defendant met the plaintiff at 2.00 a.m. and went home at 3.00 a.m. He was at the ICU the next morning at 8.30 a.m. Dr Damodaran had earlier done a neurological examination on the patient and thought that the brain had been irreparably damaged. The 2nd defendant then requested Dr Ng Siew Choon, the Cardiologist at PMC, to inform the plaintiff that the plaintiff's wife was brain dead. The patient was pronounced dead at about 8.50 p.m.. Dr Damodaran was the first person to be called and he came 15-20 minutes later. After speaking with Dr Damodaran, the 2nd defendant signed the death certificate, citing "post-partum haemorrhage with coagulapathy" as the cause of death.

The definition of post-partum haemorrage is bleeding more than 500 mls of blood within 24 hours. The diagnosis of AFE was not in the death certificate as one can only confirm it by post-mortem and histology.

AFE is an infrequent occurrence i.e. 1 in 8.000 to 1 in 80,000 deliveries. AFE is unpredictable and largely unpreventable. 85% of patients with AFE die within the first hour of clinical onset of the condition. If the patient survives, she may start bleeding. This bleeding is peculiar and difficult to stop. When the patient was wheeled into the OT, the 2nd defendant never knew for certain but it was one of the diagnoses uppermost in his mind. The patient lost about 800 mls of blood in 24 hours.

The patient had a history of threatened abortion and indeed she had a previous abortion and another threatened abortion. At 32 years of age, the patient who was a primigravida was not considered a high risk case. Although the 2nd defendant did not overlook the patient's previous abortion, he had not advised caesarean from the outset. Onset of labour occurs when e.g. there is expulsion of material by the vagina tinged with blood. The slight opening of the cervix was the beginning of labour.

There are three stages of labour, the first stage being from the onset of labour to the full dilation of the cervix. The first stage lasts an average of 12 hours in a primigravida and 7½ hours in a multigravida. The 2nd defendant did not see the need nor advise on caesarean although the deceased was in an OP position.

The foetal head was at the lower-most pole i.e. below the plane of the ischial spine. It took the 2nd defendant about 5 minutes to deliver the baby. Although the membrane had ruptured, the 2nd defendant did not record it. The rupture of the membrane signifies that delivery should be effected as soon as possible, since the amniotic fluid was coming out and the baby's head became engaged. The amniotic fluid went into the blood stream of the patient to cause AFE, through a tear or laceration.

At 9.30 p.m. on 24 May 1987, the patient started her contraction and effacement i.e. the shortening of the uterus. The 2nd defendant's own report stated that the patient was ready to deliver at 8.30 p.m., but the 2nd defendant was at home then. He denied he was late, and then hurriedly did a forceps delivery, causing the wall to wall tear in the vagina. In the labour ward, the 2nd defendant only scrubbed and used a plastic apron, without any sterile gown.

On examining vaginally, the 2nd defendant found that the patient had no time to deliver the baby normally. It was a low forceps delivery, because the baby's head was almost presenting at the opening. One of the purposes of using forceps was to rotate the head of the baby.

When the 2nd defendant sent the patient to ICU, there was nothing more the 2nd defendant could do as there were signs of brain damage. The 2nd

defendant did not make any entry in the post-natal records. Although the 2nd defendant said he had put the entries in the PMC records, these records were not produced.

Wrigley's forceps is used when the bony part of the head is pressing the perineum so that one can see the scalp of the baby without opening the valva. The 2nd defendant had no records to show the position of the baby. At the time of delivery, there was no anaesthetist standing by.

The 2nd defendant knew the baby would be born in an OP position. As the head was too far down the birth canal and baby's head had moulded to an OP presentation, the 2nd defendant could not rotate. Hence, he had to deliver in an OP position, and do a wide episiotomy which led to the suturing and the unsuturing.

The duration of stay in the labour ward was no criterion to decide if caesarean delivery was warranted. The patient, being a primigravida, took a longer time to deliver. While the patient was going through pain when in labour, she would become exhausted, but the 2nd defendant would not consider caesarean.

The 2nd defendant used the Neville Barnes forceps as the baby was below the level of the ischial spine. Forceps cause lacerations. In this case, the lacerations could have been caused during forceps delivery by the introduction of the forceps or due to the OP position. The two lacerations were 1½ cm each and on the left, one on top of the other, about ½ cm apart.

When the 2nd defendant put his 2 fingers in and examined vaginally, he found it was a direct OP position. He knew that the child was to be born in an OP position at about 5.00 p.m. on 25 May 1987, but he never alerted the nurses or PMC to be ready for possibilities.

An OP position is an abnormal way of delivery, as the normal position is occipital anterior (OA). An OP position calls for greater care on the part of the physician because about 10% of OP position babies would be stuck at the level of the spine or above and there is a higher incidence of operative (i.e. caesarean) and instrumental delivery if labour is prolonged.

The 2nd defendant saw the patient after 6.00 p.m. on 25 May 1987 and confirmed that the patient was likely to go into an OP position and yet he did not see the need to alert the nurses and he went home, despite his awareness that the delivery was OP and that greater care was necessary.

When 2nd defendant received the call at 8.30 p.m., he knew the patient was ready for delivery and he instructed the nurses to get the patient to push. The delivery was a low forceps delivery.

The Neville Barnes forceps have long shanks used for low and mid forceps delivery. These forceps cannot be rotated. Kielland's forceps are used for rotation. The 2nd defendant had used Kielland's forceps a few hundred times and he is familiar with it. He had used Kielland's forceps in PMC. But he did not use it in this case, he said, as the head of the baby was low down in the pelvis and therefore it should not be rotated. To use Kielland's forceps, he said, one must be experienced. He had stopped using Kielland's forceps for a long time, for he knew of the complications and the side effect of its use.

Tears occurred probably because of the insertion of the forceps. When forceps are inserted, pressure is put on the vagina wall and hence lacerations occur. All in all, the 2nd defendant caused 2 lacerations and he sutured them.

In most deliveries, there are some lacerations but in this case, the patient was bleeding continuously because of the underlying pathology. The 2nd defendant's records did not show what time she was wheeled into the OT and when the patient went into convulsions. The 2nd defendant estimated that the patient had lost about 300-400 mls of blood. Notwithstanding this, no blood transfusion was given. When the 2nd defendant examined the patient under anaesthesia, he thought of AFE, but rejected the idea of blood transfusion although he knew of the patient's blood group i.e. B+. The 2nd defendant did not give blood transfusion because he thought AFE was the cause of shock and not blood loss. The patient already had 3 pints of plasma expanders. Blood given in transfusion has coagulating factors.

The 2nd defendant had sutured and resutured the same 2 lacerations 7 times i.e. there was the first suturing and then there were 6 other times of resuturing, all within 1½ hours. When the 2nd defendant took the patient to the OT, the non stop oozing of blood gave him cause for concern as the blood came from the same lacerations and nowhere else. He was then concentrating on the episiotomy when 10 minutes later he noticed oozing from the sutured lacerations. He recognised at this stage the clinical picture of AFE, the signs of which are:

(1) sudden collapse disproportionate to blood loss;

(2) convulsions;

(3) respiratory difficulties; or

(4) cyanosis.

The treatment for AFE was not well known and the 2nd defendant thought the most important thing was to concentrate on the cardio-respiratory resuscitation. He also maintained circulation by intravenous fluid and he gave

Hartmann's solution because of its volume expanding effect, although Hartmann's solution was not a substitute for blood or blood plasma. He did not administer Heparin nor administer blood, blood plasma or fibrinogen in the labour ward when he recognised the symptoms of AFE. He also did not give drugs such as aminophylline or salbutamol to relax the pulmonary vessels and airways.

There were different types of shock e.g. hypovolaemic shock and cardio-respiratory shock. The 2nd defendant found the patient's shock in the labour room was cardio-respiratory shock and not hypovolaemic shock which is due to excessive bleeding.

The treatment for shock must always be directed to the cause of the shock. He did not check if the patient had a history of family blood dyscrasias i.e. blood disorder. At 11.00 a.m., 100 mg of pethidine and phanegan were given, to make the patient sleep.

The 2nd defendant was suturing the patient when she collapsed and he decided to put vaginal packing and did not suture her as the condition was deteriorating. Before he packed the vagina tight, it was friable and oedematous. When he packed the friable and oedamatous vagina, he knew there would be further lacerations. In the 2nd defendant's judgment, no caesarean was necessary.

He was at all times a consultant at PMC. He had rooms rented from PMC, pursuant to an agreement dated 24 October 1986. He also used equipment at PMC, for which there was a separate agreement dated 1 August 1984.

History of threatened abortion or miscarriage does not give rise to an indication for caesarean. There was a distinction between start of labour and established labour. A patient may have false labour which can be painful enough to need analgesics or sedatives. Sometimes a show may appear 3 days before a patient really reaches onset of labour. Cervix can efface for weeks even before the onset of labour. Here, the patient had been in established labour for 5½ hours.

For a baby to be born in an OP position, there is no requirement for the 2nd defendant to be present by the patient's bedside. A doctor could physically rotate the baby's head only at the second stage. In this case, it could not be rotated because:

(a) the head had moulded itself to the birth canal;

(b) the peculiar condition of pelvis;

(c) the muscles of the uterus were wrapped round the baby;

(d) the lower-most pole of the baby's head was in the lowest part of pelvic canal; and

(e) the baby was in distress.

When the 2nd defendant suspected AFE, he did the urgent resuscitative measures and then took the patient to the OT to meet the anaesthetist who was called earlier by the 2nd defendant. Before cross-matching, the 2nd defendant gave the patient fresh frozen plasma. He gave it in the OT before the patient's first collapse in the OT. He gave it between 9.50 p.m. and 10.00 p.m. The 2nd defendant asked for several pints of fresh frozen plasma (FFP). On that day, he used 4 packets i.e. between 1,000 and 1,200 mls. He assessed blood loss then at 450 to 600 mls. It is not uncommon for a pregnant woman to lose 1,000 to 1,500 mls of blood. If a pregnant woman loses less blood than that, there is no need to give blood transfusion. The 2nd defendant had called for 4 packets amounting to 1,500 mls because he feared coagulapathy could follow AFE. It took about 40 minutes to transfer the 4 pints of FFP.

DW2, one Choo Weng Yock, a senior medical laboratory technician and the head of blood bank at PMC, had the records of blood given on 25 May 1987. At about 9.30 p.m., he was called by the hospital from his house. He was requested to cross match the blood of the patient, which took him 1 hour. As requested, he sent up 4 packets of FFP. DW2 has been attached to this department for 11 years and is familiar with the ordering and remittance of packs of blood. He was staying in Jalan Kuching and it took him 15 minutes to reach PMC from his house. There was no one on duty at the blood bank on that day. He was on call. He would be needed only for cross-matching and for other tests. He started cross matching between 9.45 and 9.50 p.m.. The first pack of cross matched blood was sent up at 11.15 p.m.. The FFP was thawed to the temperature of 37 degrees Centigrade.

On 25 May 1987, for the patient, 5 pints of blood and 9 packs of FFP were used. 1 pack of FFP contains 180 mls.

On 26 May 1987, 2 pints of blood were given, while no FFP was given. A total of 7 pints of blood and 9 packs of FFP were given over a period of two days. The volume may be illustrated as follows:

1 pack of FFP	-	180 mls.
1 pack volume of blood	-	450 mls.
Hence, 7 packs of blood x 450	-	3,150 mls.

a	9 packs of FFP x 180	-	1,620 mls.
	Since FFP is a volume expander and		
	becomes double, the total given is	-	1,620 mls.
	Total		6,390 mls.

b DW3 was Professor Dr. V. Sivanasaratnam (Prof Dr. Siva). He was made Associate Professor and Consultant on 1 August 1987 and subsequently Senior Consultant in the Department of Obstetrics & Gynaecology. He is the Professor of Obstetrics and Gynaecology in the University Hospital Kuala Lumpur and also a Fellow of the Royal College of Obstetrics and Gynaecology, a Fellow c of the Institute College of Surgeons and the American College of Surgeons. The bulk of his work is clinical and he taught at the bedside.

According to Prof. Dr. Siva, if a patient is going to be in an OP position, the doctor has to assess the patient to see if vaginal delivery is possible. Manual d rotation is not permissible in the 1st stage of labour. In an OA position, during the 1st stage of labour, it is easier to predict the possible time of delivery but in an OP position, there is a longer duration of labour and it is more difficult to assess.

e The 2nd stage of labour is the beginning of full dilation of the cervix and the completion of the delivery of the baby and it is possible at this stage to rotate the foetal head. However, it is not possible to do an anthropoid pelvis rotation or where the position of the foetal head is in mid-cavity of pelvis. Also in lower cavity, no rotation is done as it will require dislodging the foetal head up into the mid-cavity. If a doctor makes a clinical decision that rotation f is not possible where the foetal head is in lower cavity, vaginal delivery with forceps would be the correct course. If it is in mid-cavity, caesarean is done. If the lower-most pole of the baby's head was in the lowest part of the pelvis, there would be a forceps delivery or an assisted vaginal delivery would be the method.

g If a doctor decides to use forceps, it would be the individual doctor's preference to decide on the type of forceps to use. Prof. Dr. Siva has been using Neville Barnes forceps for 29 years, as, in his view, it is a good instrument. Some doctors use Kielland's forceps but in inexperienced hands, the trauma that results can be great. Kielland's forceps should only be used h in a mal-position like OP. The primary aim of Kielland's forceps is to rotate the foetal head although his own preference would be to use a manual rotation.

If forceps are to be used in an OP position, a wide episiotomy is necessary. In all deliveries, vaginal tears do occur and that is why it is important to

i

inspect, after delivery, for any tears. Deep tears which go through the full thickness of the vaginal wall would require suturing. *a*

If there is blood loss of about 400 mls and patient has collapsed with cyanosis and dysnya, this is a very uncommon situation and one would have to think of the possibility of AFE as the cause. Immediate measures taken would be pulmonary resuscitation. Then fluids are administered. Intra-venous drip should be set up, blood is taken for cross matching and plasma expanders (e.g. amosuls, Hartmann's Solution) are given. *b*

If a patient survives the first half hour of AFE, then coagulapathy sets in and it is a difficult situation to manage. This is depletion of the various coagulating factors i.e. blood does not clot. If coagulapathy is anticipated, FFP should be given. In coagulapathy, one must give fresh blood and not stored blood, and the problem of fresh blood is the transmission of aids etc. Cyanosis is not present in other possible causes unless of course associated with AFE. *c*

If there were vaginal lacerations that continue to ooze, an exploration under anaesthesia is necessary. AFE is unpredictable and unpreventable. If the patient had a cardiac arrest and there is coagulapathy, he would pack the vagina to stop the bleeding. The mortality rate in AFE is as high as 86% and the majority of deaths occur within the 1st hour. *d*

According to Prof. Dr. Siva, it is an unusual event if a patient has an anthropoid pelvis, which is usually discovered in labour and difficult to diagnose ante-natally, although it can be determined during ante-natal stage by scanning and measurement. When in doubt, a radiological pelvimetary can be done. In most cases, a consultant can discover anthropoid pelvis 2-3 weeks before delivery *via* examination. The difference between anthropoid and normal pelvis is that an anthropoid pelvis is an unusual pelvis while a normal pelvis is gynaecoid i.e. it has the normal pelvis shape. *e* *f*

In the case of an unusual pelvis, one has to take extra care. In an anthropoid pelvis, the labour would be longer and OP position should be anticipated, which upon discovery should be recorded. It would therefore be advantageous for the doctor to know this. *g*

A 32-year old primigravida such as the patient who has had an abortion and a threatened abortion would, in the opinion of Prof. Dr. Siva, be considered a high risk. In such a situation, Prof. Dr. Siva would not have advised caesarean because of the risks involved. If Prof. Dr. Siva had known that a patient was a primigravida with anthropoid pelvis and her clinically assessed delivery time was to be at 9.00 p.m., he would have come to the labour ward at 8.50 p.m. *h* *i*

Prof. Dr. Siva agreed that a CT scan would give a more accurate picture of the pelvic brim. He did not know if the 2nd defendant did one or not.

Prof. Dr. Siva agreed that the 1st stage of labour starts with the onset of labour and a show is an indication of onset of labour and when there is a show, there is already a commencement of effacement. Effacement is the breaking up of the lower segment of uterus and cervix. First stage of labour commences with an onset of true labour right up to completion of 1st stage of labour. During this period, patient goes through pain. Tightening means contractions.

Prof. Dr. Siva was shown the medical records of the patient, exh. P4 and he agreed that at about 4.00 p.m. on 24 May 1987 contractions had commenced. On the same day, at 9.00 p.m. when the words "mild tightening" were entered, pain had begun. From 5.00 p.m. on 24 May 1987 to 11.00 a.m. on 25 May 1987, regular contractions had begun and that was the commencement of established labour. If the lower-most pole of the head was 1 cm or 2 cm from the vulva, he would use a low forceps delivery. Low forceps delivery is at outlet.

Prof. Dr. Siva agreed that Neville Barnes forceps was a long shanked forceps. He agreed that Wrigley's forceps is low forceps. Yet, whether for mid or low delivery, he would still use Neville Barnes forceps.

Prof. Dr. Siva agreed there were instances when it is too late for rotation, whether manual or otherwise. This depended on the foetal head. Rotation must be done before the head reaches the perineum. This has to be done by the doctor himself. If a baby is in an OP position and if he decided to intervene at the 2nd stage delivery, he would manipulate to bring it to an OA position. A Kielland's forceps or Bartam's forceps is used to rotate from OP to OA.

If the baby had reached the perineum, it would have been impacted and difficult to rotate. To avoid this and if there is a need for intervention, the doctor should be present. The need for intervention is when the foetus is in distress.

Prof. Dr. Siva agreed that if there was a fatality, it would be necessary to write down all that transpired and make a detailed report at which positions the head was and all that the attending doctor did. In fact, he does it in all cases, not just fatal cases.

He had used Kielland's forceps to rotate but because of its possible dangers, he preferred to manually rotate. In the hands of an expert, Kielland's forceps is a safe instrument.

He agreed under cross-examination that if he assessed the baby was due at 8.30 p.m. and in an OP position, he would not be home at 8.30 p.m. nor would

he wait till 8.45 p.m. to get a call that the baby was in distress. Given the patient's history and onset of labour from the previous day, he would be concerned and assess the need for caesarean.

He would consider caesarean necessary in the following circumstances:

(1) there is no progress in labour;

(2) foetal distress;

(3) dilatation less than 0.5 cm an hour.

The rupture of membrane is an important factor to note because the longer the membrane remains ruptured, the greater is the risk of infection. This fact of rupture should be recorded.

It was not correct for the 2nd defendant to say that when the membrane ruptures the child must be delivered as soon as possible. According to Prof. Dr. Siva, the child could be delivered within 24 hours. If there is a tear in the vaginal wall, it is the amniotic fluid that enters the mother's blood stream through the tear. The entry of amniotic fluid need not be a gush; a normal trickle would do to enter the blood stream going through circulation to ultimately result in AFE.

He agreed under cross-examination that forceps can cause lacerations in the vagina, normally 2 or 3 lacerations. When one uses forceps, the lacerations are on either lateral wall. It was possible for lacerations to occur in the case of an outlet delivery when the head was visible, because of the pressure on the wall.

In a primigravida, Prof. Dr. Siva would do a vaginal and abdominal examination every 4 to 6 hours after the initial examination, in order to assess progress in labour as well as to listen to the foetal heart. This is in addition to the recording already done by the nurses. During abdominal examination, he would assess the progressive descent of the foetal head. By means of vaginal examination, he would assess progressive effacement of the cervix and its dilatation and also to assess the progressive descent of the foetal head by noting the station of the head with reference to the ischial spine. This is ideally done as a normal practice at the University Hospital. It is vital to monitor the mother every 4 to 6 hours and all these are recorded in his charts. In University Hospital, only doctors do vaginal and abdominal examination. The nurses only listen to the foetal heart.

In the instant case, the 2nd defendant did one vaginal examination on 24 May 1987 at 9.00 p.m. and another was done the next day i.e. 25 May 1987 at

5.00 p.m. According to Prof. Dr. Siva, in University Hospital, the practice of having two vaginal examinations on two consecutive days would not happen.

Prof. Dr. Siva explained that dysfunctional uterine contraction is abnormal and the progress of labour is slow. This should be recorded, as it will decide on the mode of delivery later on and what sort of intervention is necessary. Therefore either Prof. Dr. Siva or the ward doctor would be present to monitor. During delivery in University Hospital, the ward doctor and the nursing staff would wear labour ward gown and slippers and it is not normal for a doctor to come direct from his house, scrub up and proceed to the delivery room to deliver. If the mother was in distress and although the cervix was not fully dilated, Prof. Dr. Siva would not wait for 1 hour to allow for normal delivery. He would do a caesarean.

In University Hospital, deliveries are only done by doctors. Epidural in University Hospital is given by the anaesthetist and not by the obstetrician, such as the 2nd defendant who should have known about it and should have planned to have the anaesthetist present well in advance if he was to give an epidural.

Prof. Dr. Siva uses the full partogram in University Hospital and such partogram is used in modern obstetrics. If PMC does not provide patients with full partogram or epidural, then it is not as well equipped as the University Hospital.

In the view of Prof. Dr. Siva, the Neville Barnes forceps was an instrument with a complex axis – traction.

Prof. Dr. Siva is of the view that the doctor in attendance should be at the delivery ward at least 10 minutes before 8.30 p.m. if that was the time assessed for the baby to be due. He would not leave it to the nurses. In an OP position, an episiotomy must be done and that is why it is important for the doctor to be present before telling the nurses to have the woman to push. It is not prudent to ask the patient to push when the doctor is absent. One of the reasons for the doctor to be present is that he would be able to decide whether to rotate. If the head is too low down or if it is an anthropoid, the pelvis cannot rotate. One can monitor the descent of the head before it gets impacted.

At University Hospital, there is a doctor at labour ward always and a specialist on call. The doctor is there to render aid in case of an emergency. This is not the situation in PMC, and therefore it is not an ideal situation.

In University Hospital, the time when a patient is taken from labour ward to the OT, the time a patient leaves the labour ward and the time the operation begins, would be recorded. This is to show how long the operation lasted. It

is unusual not to record these particulars. PPH is bleeding in excess of 500 mls. If death had occurred as a result of PPH, it was due to excessive loss of blood. In the case of a patient dying of PPH, she goes into hypevolaemic shock, which has nothing to do with cardiac respiratory shock.

The insertion of forceps is the introduction of forceps into the pelvic cavity without difficulty. Lacerations are caused during extraction not insertion. Generally speaking, once a tear is sutured there should be no more bleeding. If there is a bleeding tendency, then even though sutured, it would bleed. It would be an act of prudence to know of the clotting abnormalities of the patient. Prof. Dr. Siva would know if there is an overt abnormality. If there is no overt abnormality, there should be no bleeding after suturing. If the same laceration continued to bleed, he would expect an abnormality. If it continued to bleed, he would unsuture and make a proper and thorough examination to catch the bleeder. If after the second suturing, it continued to bleed, Prof. Dr. Siva would pack the vagina. He would not unsuture for the third time, because by doing so, it is making the tissues more friable. In any event, he would not suture and unsuture 6 times for fear of lacerating it further.

In the absence of post-mortem report, the doctor's diagnosis of cause of death is final. The death certificate (ABD4) shows PPH and coagulapathy i.e. excessive loss of blood was because of coagulapathy. He could not explain the exact cause of coagulapathy but he confirmed it can occur in severe PPH.

In the case of loss of blood, blood should be given, but if blood was unavailable, blood plasma could be given. If he established that blood loss was in excess of 1 litre, then he would give her blood. If PMC did not have the blood to give and had to wait for the person in charge of the blood bank to cross-match, then he agreed that PMC was not as well equipped as University Hospital.

In the University Hospital, it was the practice to record the time when the patient's pulse became unrecordable. A trained gynaecologist would be able to spot the symptoms of AFE. He agreed under cross-examination that Fibrinogen used to be given 20 years ago but it was outdated. He also agreed that giving fibrinogen was like adding fuel to fire. F.F.P. should be given.

The initial symptoms of AFE are that the patient becomes cyanotic, has difficulty in breathing and might become disorientated. If the patient survives, then coagulapathy sets in and she starts to bleed. He agreed that from the moment AFE sets in to ultimate death, it would take 24 hours and therefore a doctor has 24 hours to save a patient's life e.g. by setting up drugs and giving FFP and later blood and intubating for cardio-respiratory resuscitation.

As the patient in the instant case was bleeding, fresh blood should have been given and not stored blood. Prof. Dr. Siva would make efforts to get fresh blood from the relatives. It takes one hour to cross-match, but the 2nd defendant failed to get fresh blood from the relatives present in PMC.

A patient with PPH and coagulapathy and suspected AFE can sometimes have normal blood pressure. This is when the fluids have been pushed in and blood pressure returns to normal. Blood must be transfused first, and if it is unavailable, then saline or reconstituted plasma may be used.

Coagulapathy is a condition that results in consumption of coagulating factors, resulting in bleeding. AFE can be one of the causes of coagulapathy. If there is bleeding due to coagulapathy, packing will stop the bleeding.

If the head is in an OP position, the chances of sustaining lacerations during traction are greater. If a doctor is available when the cervix is fully dilated, the doctor can ask the patient to push.

He also agreed under cross-examination that in the course of treating a patient for AFE, he would give FFP before giving blood because of the coagulating factors in FFP. The 2nd defendant gave only Hartmann's solution first, thereby thinning the blood.

In respect of packing and repacking the vagina to stop the bleeding, since that area is tender, such repacking can lacerate.

Submissions By Counsel For The Defendants

For The 2nd Defendant

Learned counsel for the 2nd defendant submits in essence that the plaintiff has to show the following 3 ingredients of fault on the part of the 2nd defendant:

(a) that there is the normal practice which is applicable to this case;

(b) that the 2nd defendant had not adopted the normal practice; and

(c) that the course the 2nd defendant took was one which no professional doctor of ordinary skill in the position of the 2nd defendant would have taken.

It is further submitted that the 2nd defendant should not be penalised if there are different schools of thought in the medical profession.

For The 1st Defendant

For the 1st defendant, it was submitted by learned counsel that the 2nd defendant was neither the agent nor the servant of the 1st defendant and so the 1st defendant was not vicariously liable.

For The Plaintiff

Learned counsel for the plaintiff submitted that on the totality of evidence, in particular the evidence of the 2nd defendant and that of the 2nd defendant's medical expert, Prof. Dr. Siva, a case of medical negligence has been proved against the 2nd defendant and that the 1st defendant is vicariously liable.

Decision Of The Court

Burden Of Proof And Test Of Liability

In a cause of action founded upon medical negligence, the issue relating to the burden of proof and the test of liability has been succinctly stated and explained in *Clark v. Maclennan And Anor* [1983] 1 All ER 416, by Peter Pain, J. In such an action, the onus of proof normally rests on the plaintiff. However, in a case where a general duty of care arose and there was a failure to take a recognised precaution and that failure was followed by the very damage which that precaution was designed to prevent, the burden of proof lay on the defendant to show:

(1) first, that he was not in breach of any duty; and

(2) if he failed to prove that he had not been in breach of duty, that the damage suffered by the plaintiff did not result from the breach.

Accordingly, a doctor owed a duty to his patient to observe the precautions which were normal in the course of the treatment that he gave. Where a patient suffered damage after there had been a departure from the orthodox course of treatment, the court had to inquire whether the doctor had taken all proper factors into account prior to taking action in order to determine whether that departure was justified. If it was not, that departure was a breach of the duty owed to the patient.

In the *Clark* case, *supra*, it has been established that it was a general precautionary practice amongst gynaecologists that an anterior colporrhaphy should not normally be performed on a patient until at least three months after the birth of a child. The departure from that general practice by the first defendant and the second defendants' staff was not justified and accordingly there had been a breach of the duty of care owed to the plaintiff. Moreover, the defendants had failed to establish that the damage suffered by the plaintiff

had not flowed from their breach of the duty of care owed to the plaintiff. The defendants had therefore been negligent and the plaintiff was entitled to judgment against the second defendants, who in the circumstances were vicariously responsible for the first defendant.

The court has to inquire whether the doctor in question has taken all proper factors into account and whether the doctor's departure from the orthodox course can be justified on the basis of these factors. Peter Pain, J in the *Clark's* case, *supra*, explained further at pp. 424-425 as follows:

> A doctor owes a duty to his patient to observe the precautions which are normal in the course of the treatment that he gives. But, where there are two schools of thought as to the right course to be followed he may not be charged with negligence simply because he chooses one course rather than the other. Where however there is but one orthodox course of treatment and he chooses to depart from that, his position is different. It is not enough for him to say as to his decision simply that it was based on his clinical judgment. One has to inquire whether he took all proper factors into account which he knew or should have known, and whether his departure from the orthodox course can be justified on the basis of these factors.

In the case before me, the 2nd defendant had clearly departed from numerous normal practices as enumerated by the 2nd defendant's own expert witness, Prof. Dr. Siva.

Negligence Against The Defendants

From the totality of the evidence adduced in this case in the Sessions Court, I am of the view that the Sessions Court judge was correct in finding, on a balance of probabilities, that the plaintiff has established a case of medical negligence against both the 2nd defendant and the 1st defendant on the basis of vicarious liability.

As against the 2nd defendant, the plaintiff has proved that:

(1) there had been no proper monitoring of patient by the 2nd defendant who did not keep proper records;

(2) The 2nd defendant had allowed for a prolonged first stage of labour;

(3) The 2nd defendant had caused a wall to wall tear in the vagina, as evidenced in the post mortem report;

(4) The 2nd defendant did not have sufficient equipment and had not exercised proper supervision, and had failed to explain that the child was delivered by forceps;

(5) The 2nd defendant had also failed to explain the consent before performing the operation; and

(6) The 2nd defendant had failed to tell the plaintiff about AFE or coagulapathy.

From the evidence, there are also specific instances from which the 2nd defendant's negligence has been established. These instances are dealt with in greater detail below.

No Evidence Of Aseptic Condition

The 2nd defendant admitted that in the delivery room of the labour ward, he only scrubbed and used a plastic gown, not a sterile gown. The 2nd defendant admitted that he could be doing any type of work at home even gardening and then rushing to deliver. This clearly runs counter to what is required of a gynaecologist as stated in *"Traumatic Medicine and Surgery for Attorney"* Vol. 5, p 104, para. (2), the relevant portion of which reads as follows:

(2) Delivery room and equipment

> In the delivery room proper every means should be taken to conduct traffic in and out as one would in a sterile operation room … In addition sterile drapes should be available to cover the patient and the whole area made likened to a clear surgical field. For the obstetrician there should be included a sterile gown, sterile masks, a cap and sterile gloves.

This procedure is also recognised in *"Obstetrics and the New Born"* at p. 371 which is reproduced as follows:

> **Procedure**. A clean apron, cap and mask are put on. Antiseptic lotions for swabbing and for the accoucheur's hand are prepared and the delivery packs are opened or the sterile cover removed from the delivery tray. The hands and forearms are scrubbed with a brush, under running water for 2-3 minutes using an antiseptic soap or emulsion. Several rinsings are advisable. Donning of a sterile gown and gloves completes the preparation.

The 2nd defendant admitted that he never followed this procedure, although he taught his students to use a gown when entering a delivery room. However, the 2nd defendant never did so, as it is not the procedure in PMC.

According to Prof. Dr Siva, during delivery in University Hospital, doctors wear labour ward gown and slippers and make sure it is as septic as possible. It is not the norm in University Hospital to come directly from the house, scrub up and go straight to the delivery room.

Anthropoid Pelvis

The 2nd defendant testified that one of the reasons why he could not manipulate was that the patient had an anthropoid pelvis. However, he admitted that the medical records in exhs. D3 and P4 did not show such an entry. An anthropoid pelvis can be discovered during ante-natal stage by scanning and measurement, 2 to 3 weeks before delivery. Since extra care before delivery is required, and it is a rare occasion, at whatever stage it is discovered, this fact will have to be recorded. Failure to record in this instance is a reflection of a departure from the normal procedure in properly monitoring the patient's conditions by way of proper records.

Pain

The patient had indeed experienced the existence of pain when there was tightening i.e. contraction and then the long first stage of labour. Based on the medical record in exh. P-4, the 2nd defendant had prescribed pethidine and phanegon, which he said were intended to make the patient sleep. According to Prof. Dr. Siva, pethidine was a pain killer. Clearly, the 2nd defendant must have prescribed pethidine and phanegon to relieve pain as contraction has set in.

Onset Of Labour And Established Labour

According to the 2nd defendant, on 24 May 1987 at 9.00 p.m., he diagnosed that she was at the onset of labour. There was show and effacement i.e. the breaking up of the cervix to allow for full dilatation. When effacement commenced, 'tightening' or contractions commenced. This was the beginning of the first stage of labour, which resulted in pain.

There was then established labour i.e. after the onset of labour, contractions began to take a greater frequency and became more rhythmic i.e. one contraction every 5 minutes lasting 30 seconds. When this stage was reached the patient was ready to deliver i.e. move on to second stage of labour.

From 9.30 p.m. on 24 May 1987 to 9.00 p.m. of the next day i.e. at the time of delivery, the patient had been in labour i.e. from the onset of labour up to the establishment of full labour for 23 hours and 30 minutes. If labour had stretched for more than 12 hours, as in this case, the 2nd defendant as the attending doctor has to look into the cause and do a caesarean.

The 2nd defendant contended that the 12 hours referred to in the books mean established labour. However, he denied that there were contractions in order to prove that labour had not commenced. This denial apparently is in conflict with the book entitled *"Fundamentals of Obstetrics and Gynaecology"* Vol.

1, p. 119 which showed the three stages of labour, the first stage being from the onset of labour during which the effacement of the cervix is initiated or completed to the time when the cervix is fully dilated and that it lasts an average of 12 hours in primigravidae and 7½ hours in multigravidae. This period can be further divided into a relatively quiet first phase (the latent phase) during which contractions occur with increasing frequency and are of increasing duration, but are not particularly distressing to the patient, and an active second phase. In this phase the duration of the contractions increases to 60 seconds, and they recur at intervals of 3 to 5 minutes. The quiet phase lasts 8 hours on an average, the active phase 3 to 5 hours. The contractions are particularly distressing towards the end of the first stage when the membranes usually rupture.

Oxygen Tank

When the plaintiff peeped into the OT, he saw no oxygen tank inside. No nurse was called by the 1st or the 2nd defendant to rebut this. No evidence was led by the 1st or the 2nd defendant whether there was any piped oxygen in PMC.

The presence or absence of piped oxygen in PMC is a fact which is within the specific knowledge of the 1st and 2nd defendants who have therefore the burden of proving this fact: Section 106 Evidence Act 1950. The defendants have failed to discharge this burden of proof. I therefore find that there was no piped oxygen in PMC.

Occipital Posterior (OP) Position

When the 2nd defendant rushed to the labour ward for delivery, he found the head was in an OP position, meaning the head was facing backwards. As the head was too far down the birth canal and the baby's head moulded to an OP position, the 2nd defendant could not rotate. At 5.00 p.m. on 25 May 1987, when the 2nd defendant did an abdominal examination, he knew the child was going to be born in an OP position, but he admitted he did not record it in exh. P4. The OP position was an abnormal way of delivery, as the normal position was occipital anterior (OA). The OP position called for greater care on the part of the 2nd Defendant.

Partogram And Epidural

A graphic partogram would show the time of delivery. If there was to be a delay by two to four hours, then one must find out the cause of delay. Since the patient was in an established labour stage, there was actually a clear need for a partogram. The use of partogram and epidural was explained in *"Obstetrics by Ten Teachers"*, p. 184, as follows:

Management of the first stage of labour

The first stage is managed as in a normal case. Nothing can be done to correct the malposition or to influence the rotation of the head at this stage.

The frequency, duration and strength of the uterine contractions, the dilatation of the cervix and the foetal heart rate are observed in the ordinary way and recorded on a partogram. A continuous epidural block will not only give pain relief but will allow time for spontaneous rotation of the occiput into the anterior position.

Management of the second stage of labour

Manual rotation

Unless an epidural anaesthetic has already been given, a pudendal block or general anaesthesia will be required. After careful diagnostic examination the head is rotated with the hand in the appropriate direction. Thus, if the foetus is in the right occipito-posterior position the head is rotated so that the occiput travels round the right wall of the pelvis until it is directly anterior; the opposite direction of rotation is followed for a left occipito-posterior position.

If the epidural had been given, as the book suggests, the head would have turned from an OP position to an OA position.

Prof. Dr Siva clearly stated that a partogram, indeed a full partogram, is used in University Hospital. Since PMC does not provide patients with the full partogram, then PMC is not as well-equipped as the University Hospital.

Neville-Barnes Forceps/Wrigley's Forceps

Since the 2nd defendant ruled out Kielland's forceps he used Neville-Barnes forceps, which is a medium size forceps with two curves. It cannot be rotated. According to the 2nd defendant's opinion, it was a low-forceps delivery because the child's head was almost presenting at the opening. He denied that low forceps are used at the outlet. However, in *"Traumatic Medicine and Surgery For Attorney"* Vol. 5, p. 129 para. 2, it was stated as follows:

The level of the maternal pelvis at which forceps are applied will denote the type of forceps procedure, namely, low forceps at the outlet, mid forceps at the midplane, and high forceps above the midplane and approaching the pelvic inlet.

"Obstetrics Illustrated", p. 476 sanctions the use of Wrigley's forceps as Wrigley's forceps is designed for use when the head is on the perineum and local anaesthesia is being used. It is a short light instrument with pelvic curves and an English lock. The 2nd defendant did not use Wrigley's forceps as he had no anaesthetist to give a local anaesthesia. He said he could give a local anaesthesia but no anaesthetist came forward to say he could.

"Fundamentals of Obstetrics and Gynaecology", p. 404 says that "Today high forceps is condemned". Neville-Barnes forceps is a high forceps and should never be used, although according to Prof. Dr. Siva, the choice of forceps is left to the individual doctor.

It is pertinent to note that in Holland and Brews *"Manual of Obstetrics"* p. 645, the following passage appears:

> **Choice of Instrument**. It is our practice to use Wrigley's *short curved forceps* when the biggest diameter of the head is in the obstetric outlet of the pelvis, a lightly constructed pair of *long curve forceps* when the biggest diameter of the head is in the pelvic cavity, and to reserve the more complex axis-traction instrument for a very few cases in which the head lies at a somewhat higher level. Alternatively, as there is an advantage in carrying only one instrument and in familiarizing oneself with its use, the axis-traction instrument may be adapted for use in all cases; when the head is low in the pelvis the blades can be used without the traction-rods and handles like ordinary long curved forceps.

It is clear from the said passage that Wrigley's forceps should be used and that the Neville-Barnes forceps is to be used in cases where the head lies at a somewhat higher level.

Kielland's Forceps

When the 2nd defendant realised he could not manipulate by hand because of the impaction, he thought of Kielland's forceps, but did not use it because:

(a) it was a difficult forceps to use;

(b) it has to be used under general anaesthesia; and

(c) it is never used in an anthropoid pelvis.

The 2nd defendant is a qualified gynaecologist and he had used it before but did not use it in the instant case. Prof. Dr. Siva said Kielland's forceps must be used by an experienced person. The 2nd defendant had impliedly admitted that he was in the instant case less than experienced to use the Kielland's forceps and so in an actual emergency, the 2nd defendant failed to meet the standard of an experienced gynaecologist.

In fact, *"Obstetrics by Ten Teachers"* at p. 281 clearly shows that Kielland's forceps could be used to manipulate 'no matter what the position or level of the head in the pelvis'. The relevant passage reads as follows:

Kielland's forceps

The advantage of this instrument is that it allows accurate cephalic application, no matter what the position or level of the head in the pelvis. If the occiput is posterior or lateral the application is made and then the head can be rotated with the forceps to bring the occiput anterior. The forceps have a lock which allows one blade to slide on the other in the long axis, and thus the blades can lie at different levels when applied to a head which is lying transversely and is tilted. The other special characteristic is the pelvic curve. This is initially in a backward direction and then it quickly begins its forward sweep, but the tips of the blades never quite reach the plane of the shanks and handles. It is this feature which makes rotation with the forceps safe without risk of injury to vagina, bladder or rectum.

Caesarean Section

When the 2nd defendant rushed to PMC on being informed that the baby was in distress, he ruled out caesarean delivery. However, it is to be noted that the baby's head had descended as much as it could in an OP position and so any further delivery had to be *via* an episiotomy. The patient was told to push and she must have, so that the head was so well impacted that it was too late to do a caesarean. Perhaps if the 2nd defendant had remembered the fact that the patient had a history of an earlier abortion and a threatened abortion, he would have recommended caesarean.

The 2nd defendant admitted that an OP position delivery calls for greater care on the part of the gynaecologist for if labour is prolonged, instrumental delivery such as caesarean might be required.

From exh. P-4, it was evident that the patient was in pain i.e. onset of labour or commencement of first stage of labour for more than 12 hours in a primigravida and this would have warranted intervention by caesarean. According to Prof. Dr Siva, it is possible to do a casesarean in 20 to 30 minutes. Prof. Dr Siva explained that if the patient had been in the first stage of labour for more than 12 hours, there could be a possibility of her being exhausted and it would be a rule of prudence to consider caesarean.

Lacerations

There were two small lacerations on the left of the patient's vagina 1 x 1½ cm and they were parallel and near to each other. These wall to wall lacerations in the vagina were shown in the post-mortem report. The 2nd defendant sutured them, but there was bleeding again. The same lacerations were the cause of the bleeding. He put in figure-of-8 stitches. It continued to ooze.

The 2nd defendant then examined the patient under anaesthesia in the OT. He reopened the sutures and tried to look for the bleeder

The 2nd defendant agreed that forceps had caused lacerations during forceps delivery which I find as evidence of the 2nd defendant's negligence. He had altogether sutured and resutured the same lacerations seven times and all within 1½ hours. Considering the evidence of Prof. Dr. Siva who said he would not do this, I find that the fact that the 2nd defendant had sutured and resutured the same lacerations seven times within 1½ hours as constituting negligence.

Episiotomy

Because the head was in an OP position, the 2nd defendant did a wide right medio-lateral episiotomy. There was no necessity to do the episiotomy if he had come in time and manipulated the head from OP to OA. It is probable that the episiotomy wound could have triggered off the blood flow which was oozing continuously. The wound was swollen and friable.

Blood Loss

After the first suturing, there was a sudden gush of blood, with an estimated blood loss of between 200 ml to 250 ml. Over a period of 24 hours, the patient lost in the region of 800 ml of blood. When the patient went into convulsions, the 2nd defendant estimated her blood loss at about 300 ml, which was clearly an under-estimation.

As a result of the patient's loss of blood, it is necessary to restore the patient's blood volume, as it has been explained in *"Fundamentals of Obstetrics and Gynaecology"*, p. 369, under the heading "Restoration of the patient's blood volume" which reads:

> **Restoration of the patient's blood volume**
>
> If the blood loss exceeds 1000 ml, if the patient is anaemic or if she has signs of shock (tachycardia, a pulse rate raised above 100, or a systolic blood pressure below 100) blood should be transfused in adequate quantities. Blood loss is usually under estimated and at least 1000 ml should be given, the first 500 ml being given rapidly. Whilst waiting for blood an intravenous infusion of saline, or occasionally a plasma volume expander such as soluble plasma protein solution, or dextran, should be set up. Until the shock has been overcome, intra-uterine manipulations should be avoided. If the patient is apprehensive, morphine 15 mg or pethidine 100 mg may be injected. Traditionally the foot of the bed is raised in cases of shock. In the peurperal woman this causes the uterus to fall away from the pelvis and the normal situmuli of diaphragmatic movement which induce uterine contractions are lost. For this reason the patient's legs should be raised, but not her body.

a If the haemorrhage is severe and the patient shows signs of shock and hypovolaemia, it is wise to monitor biophysical and biochemical indices. An indwelling catheter is inserted to monitor urine flow, a flow of 30 ml/hour or more indicating adequate renal perfusion. Central venous pressure is a reliable measure of right atrial pressure and aids in avoiding over-transfusion. Arterial blood gases (PaO, PaCO2, pH) measured serially, enables the medical attendant b to correct metabolic acidosis and respiratory alkalosis, both of which increase pH and may lead to a decrease in cardiac output and cardiac arrhythmias. It may also be advisable to give transfusions of reconstituted packed red cells, if large amounts are needed, to avoid the introduction of white cell and plasma antigens.".

c In the instant case, due to the 2nd defendant's under-estimation of the patient's blood loss, the 2nd defendant used 4 packs of FFP amounting to between 1000 and 1500 ml. This is a departure from the ordinary reasonable skill of a gynaecologist.

d ***Post Partum Haemorrhage (PPH)***

P.P.H. means loss of more than 500 ml of blood within 24 hours. According to Prof. Dr. Siva, if death had occurred as a result of PPH, it was due to excessive loss of blood. A person dying of PPH goes into hypovolamic shock. It has nothing to do with cardio-respiratory shock as was the finding of the e 2nd defendant. Prof. Dr. Siva confirmed that coagulapathy could occur in severe PPH i.e. if there is excessive bleeding like the hidden wall-to-wall lacerations which if not attended to would lead to coagulapathy.

Hartmann's Solution

f When the patient collapsed in the labour ward, the 2nd defendant connected a drip and gave Hartmann's solution, which has the effect of thinning the blood. The 2nd defendant suspected AFE has occurred. Hartmann's solution should not have been given first. Blood transfusion should have been given, then blood plasma, and if this was not available, then Hartmann's solution g which is a solution commonly used as a means of fluid replacement in dehydrated patients.

Consent Form For Operation

At about 9.30 p.m., the 2nd defendant told the plaintiff that certain h complications had arisen and required the plaintiff to sign the consent form for operation. The plaintiff then signed it as he had no choice. The 2nd defendant was then trying to explain to the plaintiff but the plaintiff urged the 2nd defendant to assist the patient and not to delay. The consent form was never tendered in the case for the defendants and so was not an exhibit i for consideration by the court. It is the duty of the defendants to establish

that the plaintiff has given a proper or valid consent to enable the 2nd defendant to perform the operation on the patient. In the absence of the consent form, it remains uncertain if the 2nd defendant had obtained a proper or valid consent from the plaintiff for the operation on the patient.

Amniotic Fluid Embolism (AFE)

At 10.45 p.m., on 25 May 1987 when the 2nd defendant came out to talk to the plaintiff, the 2nd defendant made no mention of AFE or coagulapathy. He merely told the plaintiff that the plaintiff's wife had had a shock and her heart had stopped, and although the 2nd defendant had revived it, the plaintiff had to be prepared for the worst.

While the 2nd defendant was attempting to obtain some blood in the labour ward for cross-matching, the patient showed excessive movements of her limbs, had cyanosis of her fingers and there was excessive bleeding and she collapsed, possibly due to AFE.

According to the 2nd defendant, the basic management for AFE was cardio-pulmonary resuscitation. However, the diagnosis of AFE was not in the death certificate although the 2nd defendant knew this was the cause.

According to the 2nd defendant, 85% of patients die within the first hour of clinical onset of AFE. When the membrane burst and the baby's head became engaged, there would be a lot of amniotic fluid behind the head. This fluid went into the mother's blood stream to cause AFE, via a tear or laceration, cut or break.

When the patient went into convulsions, the 2nd defendant thought of AFE, but rejected the idea of blood transfusion. For him, AFE was the cause of shock not blood loss.

The 2nd defendant testified that the treatment for AFE was not well known. Therefore he thought the best was to give cardio-respiratory resuscitation. In *"Obstetrics and the New born"* p. 113, in respect of AFE, it was recommended that "the administration of heparin, blood, fibrinogen, and drugs to relax the pulmonary vessels and airways (amino-phylline, salbutamol) will save some of these patients". The 2nd defendant did not carry out these steps but merely gave cardio respiratory resuscitation.

Further, in *Encyclopaedia Britannica*, Vol. 13, the following passage appears:

> Amniotic fluid embolism causes sudden, severe respiratory distress, signs of shock, cyanosis (blueing of the skin), heart collapse, and circulatory failure. If the diagnosis is made promptly, oxygen, blood transfusion, and the injection of fibrinogen, a clotting factor, into a vein may be lifesaving.

Since the 2nd defendant had stated in the death certificate of the patient that cause of death was PPH with coagulapathy, he had in fact failed to recognise AFE. He only decided it was AFE after seeing the post-mortem report and never made a diagnosis of this earlier in the OT or labour ward. The failure to recognise and diagnose AFE is evidence of negligence on the part of the 2nd defendant.

Prof. Dr Siva agreed that the finding of AFE is an end result of amniotic fluid going through maternal circulation through a cut or tear and once amniotic fluid enters the blood stream, the ultimate result is AFE. From the moment AFE sets in, ultimate death would take place in 24 hours. Hence a doctor has 24 hours to save a patient's life.

Application Of S. 114(g) Evidence Act 1950

Throughout the evidence adduced by the plaintiff, the defendants and their respective witnesses, numerous names have been mentioned by the witnesses. The evidence of these named persons could have thrown some light in the case for the defendants if the defendants had called these persons as witnesses, especially in the face of the burden of proof which is cast on the defendants to show that there was no breach of duty on the part of the 2nd defendant in particular and that the damage suffered by the plaintiff did not result from the 2nd defendant's breach. The failure by the defendants to call these witnesses may be illustrated in the following instances:

(a) At 2.45 a.m. on 26 May 1987, the 2nd defendant met Dr Damu who told the plaintiff that the plaintiff's wife had suffered permanent brain damage. Dr Manavalan then took over the management at the OT that morning and helped to revive the patient twice, but neither Dr. Damu nor Dr. Manavalan was called by the defendants, to establish the management procedures adopted by these doctors to show the absence of a breach of duty.

(b) The plaintiff told the court that one nursing sister Ng gave his wife a pain relieving injection at about 4.30 p.m. and that as the effect lasted for only 20 minutes, the same nursing sister gave her laughing gas to inhale. This nursing sister Ng was never called to rebut this.

(c) The plaintiff further testified that the second pain relieving injection was given by one nursing sister Oh at 6.40 p.m.. Sister Oh was never called to rebut this.

(d) The plaintiff testified that at about 6.50 p.m. a second tank of laughing gas was given and the patient administered it herself. The defendants did not adduce evidence to rebut this.

(e) The plaintiff heard two nursing sisters discuss the amount of solution to be added to the drip as the 2nd defendant had not left any instructions. None of these nursing sisters was called to rebut this.

(f) At 8.00 p.m. the plaintiff lifted his wife to put her on the pan and saw blood covering an area beyond her buttocks and pointed it out to one Tina, but Tina was not called. Instead one Thilagawathi was called.

(g) The plaintiff peeped into the OT, there was no oxygen tank inside. No witness was called by the defendants to rebut this.

(h) One Dr. Ng, a cardiologist from PMC, spoke to the plaintiff and told the plaintiff that the plaintiff's wife was medically dead. However this Dr Ng was not called as a witness.

(i) One Dr Nadarajah examined the patient and told the plaintiff that the patient had suffered shock and had lost a lot of blood in the labour ward, where the patient was made devoid of oxygen for more than 3 minutes, which led to permanent brain damage. Dr Nadarajah was not called to rebut this.

(j) The plaintiff said that at 8.00 p.m., a nurse gave an injection and then the patient's heart beat on the screen flattened. The 2nd defendant later pronounced the patient dead. The plaintiff asked the nurse what the injection was, but the plaintiff was requested to ask the 2nd defendant. The nurse was never called to testify what the injection was.

(k) The nurse who was assisting the 2nd defendant at all material time was one assistant nurse Sarojini, but she was not called.

(l) The details of entry as to what happened post-natal were not produced.

(m) The 2nd defendant agreed with *"Obstetrics by Ten Teachers"*, at p. 184 that there should be regular vaginal examinations. The 2nd defendant maintained a nurse did that. But the nurse was not called to testify that that was done. The 2nd defendant said entries were made in the OT records, but such records, if they existed were not produced.

The circumstances adumbrated above would call for the application of s. 114(g) of the Evidence Act 1950 which reads as follows:

> The Court may presume the existence of any fact which it thinks likely to have happened, regard being had to the common course of natural events, human conduct, and public and private business, in their relation to the facts of the particular case.

Under Illustration (g), the court may presume that evidence which could be and is not produced would if produced be unfavourable to the person who withholds it.

Omissions By Defendants

From the evidence adduced in the trial it is clear that there were omissions occasioned by the defendants, as follows:

(a) Special cardio meter was never used by the 2nd defendant to monitor the heart beat of both the patient and the baby. So far as the plaintiff knew, there was no monitoring of the heart beats or of the uterine contractions.

(b) There was no record of when the membrane ruptured. Prof. Dr Siva said this should be recorded to know the course of action to follow up.

(c) There was no record to show the position of the baby at the time the forceps was used.

According to Prof. Dr Siva, if there is a fatality, the doctor should write down all that transpired. He would make a detailed report as to the position of the head and what he did. In fact he does it in all cases, not just in fatal cases.

If, as alleged by the 2nd defendant, there was dysfunction uterine contractions, Prof. Dr Siva said this was an abnormal condition which should have been recorded as it would help in the management of each particular case.

Is The 2nd Defendant A Servant Or Agent Of 1st Defendant (PMC)?

The plaintiff engaged the 2nd defendant who was working at PMC. The plaintiff was asked to pay one bill for hospital charges as in encl. (12) pp. 10-16.

In the discharge of his duties as a gynaecologist, the 2nd defendant was assisted by the nurses who were servants of PMC. These facts clearly showed that the 2nd defendant was a servant or agent of PMC. PMC produced two agreements marked D6 and D7, being the tenancy agreement and the equipment agreement respectively. These two agreements were indeed internal arrangements between the parties thereto. No notice was brought to the attention of the plaintiff about the internal arrangement, which is neither legally binding on the plaintiffs nor exempt PMC (the 1st defendant) from liability for negligence: *Olley v. Marlborough Court Ltd* [1949] 1 All ER 127 CA.

Pantai Medical Centre's Negligence

There was no evidence by PMC to the effect that one of PMC's nurses would check on the patient every half hour. PMC failed to have a stand-by

gynaecology specialist on 24-hour call for emergency cases e.g. foetal distress in the instant case. The 2nd defendant was at home when the baby was due at 8.30 p.m.. The 2nd defendant asked the nurse to tell the patient to push when the 2nd defendant knew the baby was in an OP position.

PMC has failed to have a 24-hour stand-by anaesthetist who could have been called in an emergency like this, when the head was impacted, to be able to give general anaesthesia for the use of Kielland's forceps or to give an epidural.

PMC has also failed to employ qualified and trained nurses for the purposes of the instant case. When the 2nd defendant entered the OT after getting the plaintiff to sign the consent, the 2nd defendant saw the nurses running in and out of the OT, obviously confused on seeing this emergency as they were inadequately trained to handle this situation.

PMC has further failed to provide aseptic conditions in the labour ward, such as failing to provide gowns and slippers for the gynaecologist.

PMC did not have a person in charge of the blood bank such as DW2 on 24-hour stand-by duty so that in an emergency such as the instant case, DW2 could be reached to cross-match instantly, without having to get him from home.

PMC's nurses were not instructed that it is important to record when the membrane ruptured, in order to monitor the situation and to prevent infection.

PMC has finally failed to equip themselves with the full partogram as is done in modern obstetrics, in order to graphically chart the foetal head's descent and progress.

Conclusion

On the foregoing grounds, I agree with the decision of the learned Sessions Court Judge that the 2nd defendant was liable in negligence for the suffering and death of the patient and that the 1st defendant was vicariously liable. Therefore this appeal is dismissed with costs and the judgment in favour of the plaintiff against the 1st and 2nd defendants is hereby affirmed.